DOCUMENT RESUME

ED 367 922 CG 025 270

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TITLE Inner Speech as a Primary Self-Regulatory Mechanism in Addictions Recovery.
PUB DATE May 93
NOTE 9p.
PUB TYPE Reports - Descriptive (141)

EDRS PRICE MF01/PC01 Plus Postage.
DESCRIPTORS *Alcoholism; *Drug Rehabilitation; *Inner Speech (Subvocal); *Self Control
IDENTIFIERS *Relapse

ABSTRACT

This paper presents a brief research synopsis of social speech, noting that the internalization of social speech plays an important role in the self-regulation of the personality. It then examines the phenomenon of relapse in alcohol addiction from the perspective of psycholinguistic research on inner speech, and suggests that maladaptive patterns of inner speech (arising from maladaptive patterns of social speech and self-talk) play a synergistic role in the inability of most addicts to maintain long-term sobriety. Filed observations of alcoholics-in-recovery are presented that suggest that dysfunctional patterns of inner speech may contribute to the high rates of relapse among recovering alcoholics. Approaches to further empirical study of this phenomenon are discussed, as are some practical treatment approaches which involve changing addicts' patterns of self-talk. It is suggested in a section on milieu restructuring that some of the standard patterns of interaction adopted by traditional 12-step self-help groups may need to be modified, eliminated, or instituted within a more controlled context. The paper concludes that, through better self-management, a more directed therapeutic approach which focuses on the replacement of dysfunctional patterns of social speech with more adaptation-favoring patterns of self-regulatory speech and thinking is recommended. (NB)

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ED 367 922

INNER SPEECH AS A PRIMARY SELF-REGULATORY MECHANISM IN ADDICTIONS RECOVERY

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INNER SPEECH AS A PRIMARY SELF-REGULATORY MECHANISM IN ADDICTIONS RECOVERY

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ABSTRACT: The internalization of social speech has been shown to play an important role in the self-regulation of the personality (Freud, Vygotsky, et.al.). Field observations of alcoholics-in-recovery suggest that dysfunctional patterns of inner speech may contribute to the high rates of relapse among recovering alcoholics. Approaches to further empirical study of this phenomenon are discussed as well as some practical treatment approaches which involve changing addicts' patterns of self-talk.

Since the adoption of the "disease model" of alcoholism, addiction research has mainly focused upon the physiological and social issues in the etiology of the addiction disorder, its health consequences, diagnosis, and active treatment procedures. Relatively fewer studies, however, have examined the later stages of the recovery process, especially the problem of relapse following active treatment; as a consequence this topic remains less well-understood, particularly in as far as its psychological dimensions are concerned. Statistically informed estimates suggest that the majority of all recovering addicts eventually relapse during recovery, a fact which compels recognition of the relapse phase as perhaps the most significant crisis faced by the addict-in-recovery. This paper examines the phenomenon of relapse in alcohol addiction from the perspective of psycholinguistic research on inner speech, and suggests that maladaptive patterns of inner speech (arising from maladaptive patterns of social speech and self-talk) play a synergistic role in the inability of most addicts to maintain long term sobriety.

Internalization of social speech: a brief research synopsis

Internalized social interactions have long been regarded as an important factor in the regulation of the personality. Sigmund Freud based his concept of the *superego* upon the idea of an internalized parent (Freud, 1914). Following similar lines of thought, the Russian psycholinguist Lev Vygotsky (1896-1934) developed the idea that inner speech

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originates in social interactions which are internalized to become a fundamental self-regulatory mechanism of the personality.

According to Vygotsky, the transition from social speech to inner speech follows a predictable sequence, moving from *social speech* (talk with others) to *private speech* (talking aloud to one's self), and finally to *inner speech* (silent or internal speech). While the observation of inner speech remains a methodologically complex phenomenon which, for obvious reasons, does not lend itself easily to direct empirical observation, the existance of inner speech and its influence upon patterns of thinking have been widely acknowledged as critical features in several therapeutic modes, including the *cognitive therapy* of A. T. Beck and the *rational emotive therapy* of A. Ellis.

Dysfunctional patterns of inner speech (i.e., the "scripts" addressed in cognitive therapy) have been implicated as playing a significant role in the formation of dysfunctional patterns of behavior. Similarly, the idea of teaching clients to "rewrite" these dysfunctional scripts, by adopting more effective forms of social and private speech, has been demonstrated to ameliorate many forms of dysfunctional behavior. The applicability of this line of research for the treatment of dysfunctional patterns of speech, thought, and behavior in the recovering addict is considered below.

Patterns of speech among alcoholics-in-recovery

During informal field observations of 12-step self-help addictions groups (ie., Alcoholics Anonymous, Al Anon) offered in the Chicago metropolitan area, it was noted that addicts often spoke of their recovery in terms which implicitly suggested it was a temporary condition. During one open AA meeting, for example, an anonymous presenter punctuated his autobiographical comments with observations such as "...during my current go 'round with sobriety" and "...as I am now, hanging onto the back of the wagon [by my fingernails]." While other alcoholics responded to such observations with good-natured knowing laughter, these observations also hinted at maladaptive patterns of thinking which

may contribute to the probability of this addicts eventual relapse, as in the case of a self-fulfilling prophecy.

Moreover, the dysfunctional nature of these patterns of inner speech may not go entirely unrecognized by the addicts themselves. For example, in an autobiographical presentation by "Jenny", a recovered alcoholic, the addict mentioned that during the early part of her first (unsuccessful) period of recovery, she "told herself" that she would eventually drink again, but "kept this a secret" from everyone else. When discussing her later, more successful recovery (four years of sobriety) she mentioned that now and then she thinks resuming moderate drinking ("testing the water", as she puts it) but "tells herself: why should I. I know what will happen." The comparison of these two self-reports of inner speech, one mlaldaptive and the other adaptation-favoring, clearly illustrate the correlation (if not the causal link) between adaptive inner speech and successful recovery.

Similar instances of changing patterns of speech (suggesting a corresponding change patterns of thinking) were observed in the speech of co-dependents at an open Al Anon meeting. Spouses often described their addict's recovery phase as a "remission" between bouts of illness. Others characterized the entire process of recovery as constituting for them a kind of benevolent brainwahing process through which they came to replace their former ways of talking (and thinking) about their addicts' periodic relapses with a new and different perspective which removed all guilt from the addict. Most spouses mentioned that once they came to regard their addict's as "having an illness" (now conceptualized as similar to bouts of cancer remission and relapse), their former feelings of hostility and blame seemed to fade. It seems a large part of the Al Anon therapeutic process involves teaching co-dependents to regard alcoholism like any other uncontrollable periodic illness. As we shall see, this change may have negative as well as beneficial consequences.

Considering the high relapse rate among alcoholics, it is understandable that the adoption of such an attitude would prove beneficial as a coping mechanism to reduce the distress caused by the alcoholics' periodic relapses. From another perspective, however,

the model of alcoholism *as an illness characterized by a periodic cycle of remission and relapse* may also unintentionally provide alcoholics with a rationalization for their return to a controlled form of drinking--a shift from *gamma* alcoholism (constant heavy drinking) in Jellineck's classification to *epsilon* alcoholism (binge drinking) but in which the drinker has become adapted to very long cycles of periodicity, measured in terms of months or years. Since the mental set of the addict's co-dependent(s) contributes in no small measure to the alcoholic's perception and precise identification of him-/herself in relation to the disorder, the expectation of eventual relapse (fostered by the *periodic remission illness* model) plays a non-trivial role in the conditions leading to the relapse.

Several measures which might be implemented to better understand and control such psycholinguistic etiological factors are discussed below.

(1.) *Empirical research:* Observational studies might be conducted to determine the most charcteristic patterns of dysfunctional speech using discourse analysis techniques to isolate and analyze the speech patterns of alcoholics. Characteristic patterns associated with successful recovery attempts could then be compared to the speech patterns of alcoholics with a history of multiple relapses.

It is anticipated that among the members of the successful recovery group there will be a higher instance of statements reflecting their experience with alcohol as a *fait accompli* --something already over and done with--rather than a condition hanging in the balance or inviting a periodic "testing of the waters." Ultimately, a more adaptation-favoring model of alcoholism--different from the *periodic remission illness* model--may need to be created and conveyed to suggestible addicts and their co-dependents.

(2.)*Practical treatment applications:* Assuming that an empirical correlation can be demonstrated between dysfunctional patterns of speech and increased likelihood of relapse, the next experimental step would involve isolating and modifying the specific dysfunctional patterns of speech endemic to the relapse phenomenon. In this regard, Donald H. Michenbaum's research on the clinical treatment of hyperactive children through

modification of their social, private, and inner speech (called *self instruction* or SI training) might be adopted as an effective treatment procedure. In Meichenbaum's approach (Meichenbaum and Goodman, 1971), children were coached to consciously repeat certain phrases which acted to consciously allow them to increase the level of self-control when it was necessary to offset their hyperactive urges. Similar positive results were obtained in trials aimed at reducing the cognitive distortions experienced by schizophrenics (Meichenbaum and Cameron. 1973), and to achieve stress reduction in adults (Meichenbaum, 1977). Since the alcoholic's principal concern is the control of an undesirable behavior (i.e., drinking) it is expected that an SI training approach would yield similarly positive results.

Teaching addicts new patterns of self-regulatory speech might be accomplished by borrowing Meichenbaum's technique or other well-known procedures associated with increasing the suggestibility of subjects to new patterns of information. Addicts might be repeatedly exposed to certain key phrases which replace tentative self-doubts with more assertive declarations (which treat sobriety as a battle already won). Dysfunctional patterns of speech must be corrected at the moment they occur and replaced with a more adaptation-favoring substitute (i.e., "Don't say, *I hope I won't drink again*, say instead, *I really don't need to drink again.*")

(3.) *Milieu restructuring:* The effectiveness of some aspects of the traditional 12-step self-help groups may ultimately be called into question by these research findings. As a result, some of the standard patterns of interaction adopted by these groups may need to be modified, eliminated, or instituted within a more controlled context. A case can be made, for example, that some autobiographical presentations by members might actually propogate dysfunctional patterns of self-regulatory speech and thinking (in the form of well-meaning jokes or other metaphorical expressions) which are later adopted by suggestable group members as a badge of affiliation and worldly experience, but actually convey precepts which are invidious to the efforts of the recovering addict. Likewise, the

relapse of a group member might appear to convey, if mishandled, the idea that relapses are an expected (or even *anticipated*) part of the "addictions lifestyle" and may even appear to have definite secondary gains associated with them--such as an increase in social attention (a perverse form of status), or an opportunity for the passive-aggressive punishment of significant others. In short, many 12-step groups may find themselves subject to the same criticisms voiced against contemporary prisons--as places where inmates learn only to become better criminals.

It is expected that through better self-management of social, private, and inner speech patterns, recovering addicts can be taught more effective techniques of self-regulation and behavioral control, resulting in a overall reduction of relapses into addiction. The implementation of these procedures, however, necessitates a more directed therapeutic approach (such as SI training) focusing upon the replacement of dysfunctional patterns of social speech with more adaptation-favoring patterns of self-regulatory speech and thinking.

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The author also wishes to acknowledge the anonymous members of the Chicago metropolitan area AA and Al Anon groups whose autobiographical comments were excepted for use in this paper.